California Department of Justice
P.O. Box 160447, Sacramento, CA 95816
Telephone: (916) 227-4051
Fax: (916) 227-5079

Clear Form

Patient Activity Report (PAR)

Please complete the following information by typing or printing in the required fields.

PHARMACY INFORMATION			
Pharmacy DEA No.:		**Pharmacy License No.:**	
Pharmacy Name (As it Appears on CA Pharmacy License)			
Pharmacy Address			
	City:	**State:**	**Zip Code:**
Telephone No.:		**Fax No.:**	

PATIENT INFORMATION					
Last Name				**First Name**	
AKA (Also Known As)				**Maiden Name**	
Patient Address					
	City:			**State:**	**Zip Code:**
Telephone No.:					
Social Security No.:				**Date of Birth**	

ADDITIONAL COMMENTS OR INFORMATION

AUTHORIZATION

By signing below, I certify that I am a licensed pharmacist and hereby request the history of controlled substances dispensed to the patient in my care identified above, based on data contained in the Controlled Substance Utilization Review and Evaluation System (CURES). I understand that any request for, or release of a controlled substance history shall be made in accordance with Department of Justice guidelines, that the history shall be considered medical information subject to the provisions of the Confidentiality of Medical Information Act (Civil Code §§ 56 et seq.)

Please FAX your request to (916) 227-5079
Or mal to: California Department of Justice, P.O. Box 160447, Sacramento, CA 95816

Pharmacist Signature _____ **Date** _____

Print Pharmacist Name _____
(as it appears on your CA Pharmacist License)

Pharmacist License No. _____ **Pharmacist DEA No.** _____

For Department of Justice Use Only	**Date Received**	**Date Completed**	**Initials**
	Comments		